NAME PRINTED: _____

SIGNATURE: _____

DATE: _____

SIERRA VISTA HOSPITAL
800 East Ninth Street
Truth or Consequences, New Mexico, 87901

DELINEATION OF DENTAL PRIVILEGES

I am qualified for and request the following privileges:

REHABILITATION OF DENTAL ARCHES
_____ Operative restorations
_____ Prosthetic replacement of teeth
_____ Crown and bridge preparation
_____ Implantation of teeth

EXTRACTION OF TEETH
_____ Single uncomplicated extractions
_____ Surgical removal of impacted teeth
_____ Multiple uncomplicated extractions
_____ Surgical removal of embedded teeth

INTRA ORAL SURGERY
_____ Root resections
_____ Alveoplasty
_____ Torus mandibularis
_____ Torus palitnus
_____ Minor infections
_____ Incision and drainage

EXTRA ORAL/ORAL SURGERY
_____ Minor infections
_____ Minor lacerations

_____ _____
Chief of Staff Date Chairman of the Board Date

_____
Administrator Date